Rhode Island Department of Health

Reportable Disease Confidential Case Report Form

For use by providers of clinical care

EPI-2002 FORM

If you need additional forms, access our web site at www.health.ri.gov

State of Rhode Island and Providence Plantations
Department of Health
3 Capitol Hill – Room 106
Providence, Rhode Island 02908-5097
Phone: (401) 222-2577 After hours reporting: 401) 272-5952
Fax: (401) 222-2477; (401) 222-2488

Name of Patient (Last) (First) (MI) Patient's Home Address (No. and Street)

(City or Town) State Zip code Birth date Age Patient's Telephone:

__ __/__ __/__ __ __ __ (__ __ __) __ __ __- __ __ __ __

Race ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander ☐ Asian ☐ White ☐ Black or African American ☐ Unknown

Hispanic or Latino: ☐ Yes ☐ No ☐ Unknown

Sex: ☐ Male ☐ Female ☐ Unknown

Did patient die of this illness? ☐ Yes ☐ No ☐ Unknown

Is patient a: (please check)
☐ Health Care Worker ☐ Student
☐ Day Care Worker/ Day Care Attendee ☐ Foodhandler

If yes, name and address of workplace, school or day care:

Name of disease: Clinical Onset Date Lab Diagnosis Date
___Lyme_____ / / / /

Confirmatory laboratory data, immunization status (esp. for pneumococcal and meningococcal invasive disease), dates and comments (be specific):

Reporting provider's name and address:

Phone Number: (_____) _____

If hospitalized, date admitted: / /

Hospital (Name, City, State):

Patient Medical Record #

Additional comments:

(Please print)

Name of person completing report for provider:

Address: _____

Telephone: (_____) _____ Report Date: / /

Viral Hepatitis

IgM anti-HAV	☐ Positive	☐ Negative	☐ Not Done
HBsAg	☐ Positive	☐ Negative	☐ Not Done
IgM anti-HBc	☐ Positive	☐ Negative	☐ Not Done
Chronic HbsAg carrier	☐ Yes	☐ No	☐ Unknown
ELISA anti-HCV	☐ Positive	☐ Negative	☐ Not Done
RIBA--HCV	☐ Positive	☐ Negative	☐ Indeterminate

RT-PCR HCV _____ Genotype _____

Liver Function Tests: SGOT (AST): _____ SGPT (ALT): _____ Bilirubin: _____

Sexual preference ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Unknown

History of IV drug use ☐ Yes ☐ No ☐ Unknown

Pregnancy status ☐ Yes- Patient is pregnant ☐ Sexual partner is pregnant ☐ Unknown

Lyme Disease

ERYTHEMA MIGRANS:

Physician diagnosed EM 5 cm (2 in)?	☐ Yes	☐ No	☐ Unknown

RHEUMATOLOGIC

Arthritis (objective joint swelling)	☐ Yes	☐ No	☐ Unknown

NEUROLOGIC

Bell's palsy or other cranial neuritis?	☐ Yes	☐ No	☐ Unknown
Radiculoneuropathy?	☐ Yes	☐ No	☐ Unknown
Lymphocytic meningitis?	☐ Yes	☐ No	☐ Unknown
Encephalitis/Encephalomyelitis?	☐ Yes	☐ No	☐ Unknown
Antibody to *B. burgdorferi* higher in CSF than serum?	☐ Yes	☐ No	☐ Unknown

CARDIOLOGIC

2nd or 3rd degree AV block?	☐ Yes	☐ No	☐ Unknown

OTHER HISTORY

Name of antibiotic used this episode?

LYME VACCINE

Was patient vaccinated?	☐ Yes	☐ No	☐ Unknown

If yes, specify number of doses: _____

Indicate date(s) vaccinated: ___/___/___ ___/___/___ ___/___/___

LYME DISEASE LABORATORY REPORT

Elisa (EIA)	☐ Positive	☐ Negative	☐ Equivocal	☐ Not Done
IFA	☐ Positive	☐ Negative	☐ Equivocal	☐ Not Done
Western Blot	☐ Positive	☐ Negative	☐ Equivocal	☐ Not Done